State of Colorado
Medical and Dental Enrollment Form

Space is provided on this form for listing your spouse and six dependent children. To list more than six dependent children, please fill out an additional enrollment form, and mark in the statement below 'Dep-6' line, whether the form is the original or an additional sheet.

"PLEASE PRINT OR TYPE IN BLACK INK"

DPA

SECTION A

Emp Social Security #	Emp Last Name ☐ check if new	Emp First Name	M.I.	Work Phone	Home Phone	Effective Date

Street Address ☐ check if new	City	State	Zip	County	Original Hire Date	Dept/Agency Org ID

SECTION B: ENROLLEES

LIST PERSONS TO BE ENROLLED

	LAST NAME	FIRST NAME	MI	CHECK ONE	DATE OF BIRTH	SOCIAL SECURITY #	STUDENT	*REL CODE	COVERAGE IS FOR: MEDICAL	COVERAGE IS FOR: DENTAL	PRIMARY CARE PHYSICIAN (PCP)
Emp				☐M ☐F			☐		☐	☐	
Spouse				☐M ☐F			☐		☐	☐	
Dep-1				☐M ☐F			☐		☐	☐	
Dep-2				☐M ☐F			☐		☐	☐	
Dep-3				☐M ☐F			☐		☐	☐	
Dep-4				☐M ☐F			☐		☐	☐	
Dep-5				☐M ☐F			☐		☐	☐	
Dep-6				☐M ☐F			☐		☐	☐	

If you require coverage for more than six dependent children print additional sheets and check the appropriate box to the right. ☐ Original ☐ Additional

SECTION C: PLANS

Select One MEDICAL Plan:	Payroll Use Only	Select One MEDICAL Plan Coverage Category	Pretax Premiums MEDICAL
☐ Anthem Liberty EPO	(204) (205)	☐ Employee Only	☐ Deduct Premium Pretax
☐ Anthem Centennial PPO	(207) (208)	☐ Employee + 1dependent	☐ Deduct Premium Post tax
☐ Kaiser Permanente HMO	(219) (220)	☐ Employee + 2 or more dependents	
☐ PacifiCare HMO	(216) (217)		
☐ San Luis Valley HMO	(228) (229)		
☐ Decline Coverage			
Select One DENTAL Plan:	(237) (238)	**Select One DENTAL Plan Coverage Category**	**Pretax Premiums DENTAL**
☐ Delta Dental Basic Plan	A	☐ Employee Only	☐ Deduct Premium Pretax
☐ Delta Dental Basic PLUS Plan	B	☐ Employee + 1dependent	☐ Deduct Premium Post tax
☐ Decline Coverage		☐ Employee + 2 or more dependents	

***RELATIONSHIP CODES**

(enter appropriate code letter in REL CODE column above)

- **B** - Birth Child
- **G** - Grandchild
- **F** - Foster Child
- **A** - Adopted Child
- **M** - Married Spouse
- **S** - Stepchild
- **D** - Disable Child
- **C** - Court Order
- **L** - Common law

(See "Affidavits" on the instruction sheet of this form.)

SECTION D

Other Coverage: Are you or any of your eligible dependents covered by another medical or dental plan? If yes, complete below:

Medical Plan Name:	Plan Number:	Medical Plan Name:	Plan Number:

Payroll Authorization: Must be signed and dated.

I hereby authorize my employer, until this authorization is revoked by written notice, to deduct from each paycheck the amount applicable for the coverage options I have selected. I hereby certify that the above information and any attachments thereto are true and correct. I understand that misrepresentation or falsification will subject me to penalties and possible legal action. I hereby certify that I have read the enrollment materials and accept the terms and conditions described in the enrollment materials, including the reverse side of this form. I also agree to all of the terms and conditions as defined by the plans selected.

Employee Signature: Date:

Please make and retain a copy of this form.
Submit the original to your agency payroll and personnel administrator.

Print Reset

General Information
This form and the additional enrollment materials included in the "Benefits Guide 2004" represent the complete enrollment materials package. These materials represent only a summary of the state's group benefit programs. If any discrepancy exists between these materials and the group master contracts, the group master contracts will govern.

The State Benefit Plans section of the State Personnel Director's Administrative Procedures contain descriptions of the procedures governing benefits eligibility and changes. A copy of the procedures is available from your agency payroll or personnel administrator.

Fraud
It is unlawful for any employee, employee's dependent(s) or other individual(s) to knowingly and intentionally provide false, incomplete, or misleading facts or information on any benefits enrollment form, affidavit, or other document for the purpose of defrauding or attempting to defraud the State of Colorado with regards to the aplication for benefits or claim for benefits. Penalties may include imprisonment, fines, denial of enrollment in any or all of the state's group benefit plans, civil damages, termination of enrollment in any or all of the state's benefit plans, or as provided in regulations, statutes, and written directives.

Irrevocability of Pre-Tax Premium
If you elect the Pre-Tax Option, your election is irrevocable for the plan year except as provided by the State of Colorado Salary Reduction Plan Document. Refer to 'Exceptions to the Irrevocability Rules' for information regarding the limited circumstances under which you may be permitted to change your election. If you wish to retain the option to cancel your coverage during the plan year, do not elect the Pre-tax Premium option.

Dependent Children Age Limitations
Your eligible dependent child(ren) include natural, adopted, foster and stepchildren. Children who are dependent upon you as a major source of financial support are eligible through December 31 of the calendar year in which they turn age 19; or through the end of the month of marriage, or entering military service; or through December 31 of the calendar year in which they are no longer a full-time student, but no longer than the end of the month in which a full-time student turns age 24; or an unmarried child of any age who is medically certified as disabled by the carrier no matter when the disability occurred.

Affidavits and Legal Documentation
- If you and your eligible dependents, common law spouse, grand and/or foster child(ren), adopted child(ren) and court ordered children are currently enrolled for medical and/or dental benefits for 2004 and have already provided affidavits/legal documentation for the above listed dependents, you will not be required to provide further documentation for the 2004 plan year.

- If you and/or your eligible dependents are enrolling for the first time in the state's medical and/or dental benefits for the 2004 plan year, you must provide all applicable affidavits/legal documentation.

Your Signature On This form:
1. Authorizes your employer, the State of Colorado, the right to deduct the applicable and appropriate premiums according to the terms specified in "Payroll Authorization" on the front side of this form.
2. Does not constitute a binding contract or provide any employment guarantees between employees, eligible dependents, and the State of Colorado.
3. Serves as authorization for the medical and dental carriers to release information to government agencies when required under appropriate federal or state legislation or regulation, or pursuant to legal processes, and to release and obtain medical information to or from other appropriate agencies, providers, and carriers for the purpose of providing necessary health care and administrative services.
4. Serves as an agreement between the employee and the medical and/or dental carriers that you will utilize the appeal procedures established by the medical and/or dental carriers for resolving disputes. Depending upon the conditions set forth by each carrier, this agreement may require utilizing binding arbitration instead of a court trial for dispute resolution.